

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

 DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

 MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

27970

Registration District No.

Primary Registration District No.

Registrar's No.

323

1. PLACE OF DEATH:

(a) County Cape Girardeau
 (b) City or town Cape Girardeau
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: St. Elizabeth's Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution Entire life (Specify whether years, months or days)

3. (a) PRINT FULL NAME

HERMAN LEONARD OBERMILLER

3. (b) If veteran,

name war

none

3. (c) Social Security

No.

none

4. Sex

Male

5. Color or

race

white

6. (a) Single, widowed, married,

divorced

married

6. (b) Name of husband or wife

Carla Obermiller

6. (c) Age of husband or wife if

alive

69 years

7. Birth date of deceased

May 21-1866

(Month)

(Day)

(Year)

8. AGE:

Years

75

Months

3

Days

8

If less than one day

hr.

min.

9. Birthplace

Jackson

(City, town, or county)

Mo.

(State or foreign country)

10. Usual occupation

Farmer

11. Industry or business

12. Name August Obermiller

13. Birthplace

Germany

(City, town, or county)

(State or foreign country)

14. Maiden name

Justina Unterreiner

15. Birthplace

Germany

(City, town, or county)

(State or foreign country)

16. (a) Informant's own signature

Glen H. Obermiller

(b) Address

775 Perry Cape Girardeau Mo

17. (a)

Burial

(b) Date thereof

Aug 31-1941

(Burial, cremation, or removal)

(Month) (Day) (Year)

(c) Place: burial or cremation

Riverside Heights

18. (a) Signature of funeral director

J. M. Thompson

(b) Address

4-1-410

19. (a)

(Date received local registrar)

(b)

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State

Mo

(b) County

Cape Girardeau

(c) City or town

Jackson

(If outside city or town limits, write "RURAL")

(d) Street No.

(If rural, give location)

(e) If foreign born, how long in U. S. A.?

years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month

Aug

day 29th

year 1941

hour 8:30

minute 25

P.M.

21. I hereby certify that I attended the deceased from

Oct 15-

1940, to Aug 29, 1941

that I last saw him alive on Aug 29, 1941

and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage

Duration 17 days

Due to

Cerebral Sclerosis

several years

Due to

Hypertension

3 years

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

T. E. Ruff

(M. D. or other)

M.D.

Address

Jackson Mo

Date signed 9-1-41

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

Gene Cracraft....., Registered Apprentice No. 300
working under my personal supervision.

Signed Lynna Steele.....

Licensed Embalmer No. 2476

P. O. Address Jackson MO

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

STANDARD CERTIFICATE OF DEATH

State File No. 27970
Registrar's No. 323

Registration District No. 125

Primary Registration District No. 3009

1. PLACE OF DEATH:

(a) County Cape Girardeau
(b) City or town Cape Girardeau
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution S.E. Mo. Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 12 days
In this community Entire life (Specify whether years, months or days)

3. (a) PRINT FULL NAME

German L. Obermiller

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex m

5. Color or race w

6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive

7. Birth date of deceased

(Month) (Day) (Year)

8. AGE:

Years Months Days If less than one day min.

9. Birthplace

(City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

(City, town, or county) (State or foreign country)

14. Maiden name

15. Birthplace

(City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a)

(Burial, cremation, or removal)

(b) Date thereof

(Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a)

(Date received local registrar)

(b)

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Cape Girardeau
(c) City or town Jackson
(If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 19

year 1941 hour 10 minute 19 M.

21. I hereby certify that I attended the deceased from

that I first saw him alive on and that death occurred on the date and hour stated above.

Immediate cause of death

Duration

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur?

(City or town)

(County)

(State)

(b) Did injury occur in or about home, on farm, in industrial place, in public place?

(Specify type of place)

While at work?

(c) Means of injury

23. Signature

(M. D. or other)

Address

Date signed

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

